DRAFT

Issue Brief on Performance Measures for Dual Eligible Beneficiaries

Kate McEvoy. Esq.
Associate Director, Health Services & Supports
DSS
July 18, 2012

Issue presented:

Measuring the impact of integrated care initiatives, which seek to align Medicare and Medicaid-funded services and supports for individuals who are eligible for coverage under both programs, is challenging. Key aspects of these challenges include:

- lack of alignment in measuring success for Medicare and Medicaid, each of which have specific coverage boundaries that can result in differences in perspective with respect to defining value (e.g. a more acute/episodic v. long-term care perspective);
- heterogeneity of the populations that are included in the descriptor, dual eligible;
- overcoming the more historically typical one disease/one setting measurement approach to reflect the reality of incidence of co-occurring chronic conditions and need to measure impact across care settings;
- adapting existing measures to reflect more emphasis on effective maintenance of conditions as opposed to cure; and
- developing measures where none exist or the measures that exist have not yet been finalized for use in an existing measure set (e.g. the degree to which care planning is "person-centered", connections between health care and community-based service providers, beneficiaries' sense of autonomy and self-direction).

Selection of performance measures must take into account and reconcile the above concerns, and also must also promote feasibility of implementation.

National Background:

Three key sources are briefly synopsized below. These include:

1) relevant sections of the Health and Human Services Administration (HHS) Final Rule on Accountable Care Organizations (ACOs);
2) draft memo guidance from the Center for Medicare and Medicaid Innovation (CMMI) on managed fee-for-service (MFFS) quality measure concepts; and
3) a report issued by the National Quality Forum on performance measurement for dual-eligible individuals.

Final Rule on ACOs practice measures requirements. Page numbers indicated in this section cite to the Rule, which is available at the link identified in the reference section. The Final Rule on ACOs includes 33 practice measures by which ACOs will be evaluated. [p. 327] These include:

I. Related to the aim of better care for individuals:

- seven measures of patient/caregiver experience [method: survey]:
  - CAHPS: Getting Timely Care, Appointments, and Information
  - CAHPS: How Well Your Doctors Communicate
  - CAHPS: Patients' Rating of Doctor
  - CAHPS: Access to Specialists
  - CAHPS: Health Promotion and Education
  - CAHPS: Shared Decision Making
  - CAHPS: Health Status/Functional Status

- six measures of care coordination/patient safety [method unless otherwise indicated: claims]
  - risk standardized, all condition readmission [**Note: pending finalization**]
  - ambulatory sensitive conditions admissions: COPD (AHRQ Prevention Quality Indicator #5)
  - ambulatory sensitive conditions admissions: congestive heart failure (AHRQ Prevention Quality Indicator #8)
  - percent of PCPs who successfully qualify for an EHR Incentive Program Payment [method: EHR Incentive Program Reporting]
  - medication reconciliation: reconciliation after discharge from an inpatient facility [method: GPRO web interface]
  - falls: screening for fall risk [method: GPRO web interface]

II. Related to the aim of better health for populations:

- eight measures related to preventative health [method: GPRO web interface]
  - influenza immunization
  - pneumococcal vaccination
  - adult weight screening and follow-up
  - tobacco use assessment and tobacco cessation intervention
  - depression screening
  - colorectal cancer screening
  - mammography screening
  - proportion of adults age 18+ who had blood pressure measured within preceding 2 years

- six measures related to individuals identified as at risk by reason of diabetes
  - diabetes composite (all or nothing scoring): hemoglobin A1c Control (<8 percent)
  - diabetes composite (all or nothing scoring): low density lipoprotein (<100)
  - diabetes composite (all or nothing scoring): blood pressure <140/90
  - diabetes composite (all or nothing scoring): tobacco non-use
  - diabetes composite (all or nothing scoring): aspirin use

        - diabetes mellitus: hemoglobin A1c poor control (>9 percent)

    - one measure related to individuals identified as at risk by reason of hypertension

        - hypertension: blood pressure control

    - two measures related to individuals identified as at risk (or frail elderly) by reason of ischemic vascular disease

        - ischemic vascular disease: complete lipid profile and LDL control < 100 mg/dl
        - ischemic vascular disease: use of aspirin or another antithrombotic

    - one measure related to individuals identified as at risk (or frail elderly) by reason of heart failure

        - heart failure: beta-blocker therapy for left ventricular systolic dysfunction

    - two measures related to individuals identified as at risk (or frail elderly) by reason of coronary artery disease

        - coronary artery disease composite (all or nothing scoring): drug therapy for lowering LDL-cholesterol
        - coronary artery disease composite (all or nothing scoring): angiotensin-converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy for patients with CAD and diabetes and/or left ventricular systolic dysfunction

CMS will require a standardized, patient experience of care survey based on CAHPS, and will in 2012 and 2013 pay for administration of such survey for participant ACOs [p. 327]

ACOs must report completely and accurately on all 33 measures for all reporting periods in each performance year. [p. 328] For each measure set/domain, the ACO must report on a random sample consisting of at least 411 assigned beneficiaries [or if less than 411, all beneficiaries]. [p. 336] GPRO web interface will be a primary mechanism for reporting of data, and CMS has agreed to pre-populate the interface with demographic and utilization information for beneficiaries assigned to the ACO [p. 336]

Reporting of quality performance standards will follow the Physician Quality Reporting System but is pending finalization. [p. 540]

CMS draft guidance on quality measures. Related to its administration of the process of state applications for support under the Demonstration to Improve Care for Dual Eligible Individuals, CMS on June 7, 2012 issued a document entitled "DRAFT Managed Fee-for-Service Quality Measure Concepts". Connecticut has elected to use a MFFS approach. This concept paper confirms that while CMS will "evaluate the demonstrations based on a broader array of quality measures and concepts" [still to be determined], it will for purposes of state eligibility for

Medicare performance incentive payments focus on measures that are identified in the body of the paper.

CMS sets the context for performance measurement by identifying six measurement domains that are aligned with the CMS National Quality Priorities Measurement Framework:

- care coordination;
- clinical care;
- person-and caregiver-centered experience and outcomes;
- safety;
- efficiency and cost reduction; and
- population/community health.

Within the above domains, CMS proposes to use the following as the core set of measures for purposes of MFFS initiatives:

- all cause hospital readmissions;
- ambulatory care-sensitive condition hospital admissions;
- follow-up after hospitalization for mental illness;
- flu immunization; and
- number of emergency department visits for ambulatory sensitive conditions.

Further, CMS intends to augment the measure set over the three-year period of the Demonstration, as follows:

- Year 2 - care transitions, depression screening and follow-up care, survey data to accompany claims data for immunizations; and
- Year 3 - screening for fall risk.

Additionally, CMS will require that states select and report on one of the following process measures:

- individualized care plans: X% of members with care plans by specified timeframe;
- discharge follow-up: X% of members with Y days between discharge to first follow-up visit; or
- self-direction: X% of care coordinators that have undergone State-based training for supporting self-direction under the demonstration

National Quality Forum performance measures report. Page numbers indicated in this section cite to the report, which is available at the link identified in the reference section. In June, 2012, the National Quality Forum (NQF) released a report entitled "Measuring Healthcare Quality for the Dual Eligible Beneficiary Population". This report reflects the work of the Measure Applications Partnership (MAP), a multi-stakeholder expert group that was convened by the NQF acting as contractor to the Department of Health and Human Services (HHS). MAP was charged with reviewing existing performance measures, assessing gaps, and making

recommendations on a set of specific, actionable measures related to evaluating success in meeting the needs of dual-eligible beneficiaries.

Setting context, MAP identifies "six core aspects of care that . . . could provide high-value signals of improvement over time", including:

- individuals' quality of life and functional status;
- individuals' preferences and experience of care, as well as engagement in decisions about care;
- coordination of care among various providers and settings;
- provision of follow-up care and availability of community-based services and supports; and
- ongoing management of chronic health conditions and risk factors for chronic conditions. [p. 3]

MAP builds upon prior work with adult performance measurement sets by recognizing features of the dual eligible beneficiary population that require special attention: incidence of co-occurring chronic conditions, tendency to be subject to care transitions and to be cared for by a range of treating and other service providers, and interest in achieving greater "person-centeredness" in care coordination. Further, MAP acknowledges the heterogeneity of the various populations that fall within the descriptor, dual eligible (e.g. individuals with physical disabilities, individuals with developmental disabilities, individuals with SMI, older adults).

In light of these features, MAP identifies need for 1) tailoring of existing measures so that they are cross-cutting with respect to conditions and settings; and 2) drafting of new measures to fill gaps related to assessing person-centeredness in care planning, connections among providers and across care settings, and beneficiary autonomy and sense of self-direction. MAP also identifies the following as its vision statement with respect to performance measurement:

> *In order to promote a system that is both sustainable and person- and family-centered, individuals eligible for both Medicare and Medicaid should have timely access to appropriate, coordinated healthcare services and community resources that enable them to attain or maintain personal health goals.* [p. 7]

Employing a set of guiding principles that include such features as parsimony, feasibility of implementation and inclusivity, MAP has endorsed a set of seven core measures (the "Starter Set") within five domains (quality of life, care coordination, screening and assessment, mental health and substance abuse) [p. 8] that it commends as being the "most promising for use in the short term" [p. 14]. Further, MAP has endorsed a broader set of 26 measures (the "Expansion Set") that capture a more comprehensive range of focus areas [these are featured in Appendix G]. The set of seven core measures includes the following:

- screening for clinical depression and follow-up plan;
- initiation and engagement of alcohol and other drug dependence treatment initiation and engagement;
- Consumer Assessment of Healthcare Providers and Systems (CAHPS);
- 3-item care transition measure;
- hospital-wide all-cause unplanned readmission;

- plan all-cause readmission; and
- falls: screening for fall risk. [pp. 14-15]

The report then details related focus points including gaps in existing measure sets [p. 22], issues presented by measures of quality in Medicaid-funded home and community-based services (HCBS) and need for alignment of measure sets across federal programs [p. 31].

References:

Health and Human Services Administration Final Rule on Shared Savings: Accountable Care Organizations, available at:

http://www.regulations.gov/#!documentDetail;D=CMS-2010-0259-1591

"Measuring Healthcare Quality for the Dual Eligible Beneficiary Population", National Quality Forum, June, 2012, available at:

http://www.qualityforum.org/Setting_Priorities/Partnership/Measure_Applications_Partnership.aspx